



Destabilising institutions to make healthcare more equitable: clinicians, educators, and researchers co-producing change

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5 **Destabilising Institutions to make Healthcare more equitable: Clinicians, Educators, and**
6 **Researchers co-producing change**
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Destabilising institutions to make healthcare more equitable: clinicians, educators, and researchers co-producing change

Tim Dornan, Gráinne P Kearney, and Eeva Pyörälä

Disturbances and conflicts in everyday medical work ... challenge the medical social system to understand and manage complexity, identify the dynamics of contradictions, and utilize them in emancipatory transformations. (Engeström and Pyörälä 2020 – this issue)

If medicine's purpose is to optimise care and education's purpose is to optimise learning, medical education research's purpose is to optimise learning to care. Elite academics use a linear, hierarchical model to achieve this: they produce research outcomes, which educators translate into educational outcomes, and jobbing clinicians translate into health outcomes. So far, so simple; but, according to expert opinion, unlikely to improve healthcare. (Teodorczuk et al. 2017) Eight articles in this issue of Medical Teacher use Engeström's seminal theory of Expansive Learning (part of a broader framework known as Cultural-Historical Activity Theory [CHAT] (Engeström and Pyörälä 2020)) to show that the translational model can be theoretically simplistic and practically ineffective. Collectively, the authors ('we') theorise and empirically validate a conjoint practice of caring, learning, and research, co-produced by its own stakeholders. This commentary explains why hallowed institutions need to change if the scholarship of medical education is to achieve its full potential.

We use CHAT to identify 'structurally accumulated tensions' in care, education, and research, resulting from the unopposed effects of neoliberal politics, 'evidence', and/or theory. We show adverse consequences of medical education's obsession with assessment. We show how practice communities, which risk stagnating amidst irreconcilable tensions, can co-produce 'possibility knowledge'. Rather than teaching students and doctors to be competent but not necessarily capable, we show how undergraduate, postgraduate, and continuing education can help patients and practitioners learn together to practise well. We describe hierarchical social positioning, fragmented practice communities, and irrational variation in practice. We identify tensions and ruptures between specialties, and between specialism and generalism. This complexity challenges the weakest link in the translational model of contemporary medical education: transition into practice. For patients to benefit, we argue, the whole contemporary institution of medical education needs to embrace complexity.

CHAT (Engeström and Pyörälä 2020) is orientated towards social justice: a fair and equal society in which each individual matters. CHAT provides a theoretical platform to make social boundaries permeable, involve all stakeholders, and harness 'fluid' relationships between them to drive change (Varpio and

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3 Teunissen 2020). It treats social contexts and the activities within them as inseparable. Whilst this confounds
4 the simplicity of the translational model, it allows non-linear relationships between cause and effect in
5 complex systems (Regehr 2010) to produce large outputs from small inputs. The politics of this type of
6 change is not ‘top-down’; rather, it emerges from stakeholders’ co-participation in determining and pursuing
7 goals (e.g. Morris et al. 2020). We made real live patients, who ‘more than anything else arouse involvement,
8 effort, emotion, excitement and frustration among front-line staff’ (Engeström 2018) the *object*¹ of the
9 collective *activities* of clinical care, education, and research. This generated the design concept for a new
10 undergraduate curriculum (Bleakley 2020). It helped socially disadvantaged Brazilian women be treated
11 respectfully, rather than used as tools for obstetric residents’ learning; a highly effective, continuing systemic
12 change resulted. (Grilo Diniz et al. 2020) Acknowledging the stultifying effect of standardizing human
13 behaviour for Objective Structured Clinical Examinations (OSCEs) opened up possibilities to release latent
14 energy for change in medical education. (Reid et al. 2020)

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16 Subtle changes in the *subject* of educational activity can also catalyse change; for example, a simple
17 intervention changed medical students from observers, becoming competent for practice, into residents-in-
18 waiting, becoming capable by participating in practice (Gillespie et al. 2020). A humble mediating *tool* - a
19 pen filled with purple ink – mediated students’ identity change. As residents-in-waiting, they now responded
20 to nurses’ requests to write orders so that patient care could proceed (Gillespie et al. 2020). Written
21 instruments, another example of a mediating tool, had a pivotal role in improving collaboration between GPs
22 and specialists, and between the many practitioners caring for elderly people with complex needs (Engeström
23 and Pyörälä 2020; Meijer et al. 2020). Official *rules* made by government and insurers impeded collaboration
24 between Dutch specialist and generalist care providers. (Meijer et al. 2020). Unofficial *rules* also influenced
25 educational activity; for example, by perpetuating medical students’ unsafe participation in practice (Gillespie
26 et al. 2020) and trivialising patient-centred behaviour (Reid et al. 2020). Regulators had a strong, potentially
27 negative effect on a national practice *community* by positioning themselves as proxies for real patients
28 (Gillespie et al. 2020; Meijer et al. 2020; Reid et al. 2020).

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30 The importance of *division of labour* is obvious when one considers the proliferation of professions
31 and specialities that surround patients. It is here that the practical ability of CHAT-inspired research to
32 expand learning and care comes into its own. Far from elite researchers taking primary responsibility for
33 education development, patients, care-givers, students, managers and other interested parties work together to
34 research and implement change. This takes place in purposefully planned Change Laboratory interventions,
35 with which we improved multi-agency care, (Engeström and Pyörälä 2020) obstetric residency and medical

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¹ We have used italics to denote the six main components of any activity system: activity, object,
subject, tools, rules, community, and division of labour.

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3 student placement education, (Morris et al. 2020) and collaboration between specialists and generalists
4 (Meijer et al. 2020). CHAT provided a lens through which to examine interprofessional collaboration, in all
5 its on-the-ground fluidity, and to show why followership is as important to leadership as the reverse (Varpio
6 and Teunissen 2020). CHAT regards such tensions as both inescapable and, when clearly understood, a
7 potent driver of change. This results, not from bringing multi-voiced communities into perfect harmony, but
8 from synchronising dissonance so that stakeholders can ‘collectively form concepts in the wild’. (Engeström
9 and Pyörälä 2020)

14 The eminent sociologist, Dorothy Smith, encouraged researchers to examine the social
15 ‘institutions’ (which does not just mean official organisations or buildings), which organise peoples’
16 worlds and everyday work. She urged critical scrutiny of how institutions’ politically elevated positions
17 ‘on the 14th Floor’(Smith 2008) afford power to organise people’s work whilst remaining detached from
18 on-the-ground actualities. CHAT helped us turn tensions between politicised institutions and clinicians’
19 real work into energy for change: students labouring to show regulators they were competent were
20 transformed into trainee doctors becoming capable of caring for patients; (Gillespie et al. 2020; Reid et al.
21 2020) and generalists and specialists, divided from one another by the competing demands of government
22 and insurers, became collaborators in patient care (Meijer et al. 2020). CHAT helped a number of authors
23 change the famously patriarchal institution of Obstetrics and Gynaecology. They addressed the bullying
24 and harassment of trainees (Morris et al. 2020) and the abuse of women for training purposes (Grilo Diniz
25 et al. 2020), and turned interprofessional rivalry into a collaborative focus on the best interests of women
26 in labour (Varpio and Teunissen 2020).

35 This critique of institutions invites two further questions: why have such tensions arisen in the
36 humane pursuit of education for clinical care, and where should we go from here? Karl Marx argued that
37 a fundamental contradiction between the ‘exchange value’ (what you can sell something for) and ‘use
38 value’ (how useful it is in your own hands) affects activities in all societies. (Engeström 2018) Two
39 articles illustrate this contradiction using the example of OSCEs in contemporary medical education.
40 (Gillespie *et al.*, 2020; Reid *et al.*, 2020) At present, psychometricians calculate precise cut-off levels,
41 above which students can exchange an OSCE score for a medical qualification and the right to earn
42 money; medical schools exchange evidence that their assessments are reliable for the right to graduate
43 students; and regulators exchange oversight of reliable exams for the power to regulate medical
44 education. Reliable measurement dominates a ‘commodity market’ of medical education. Students and
45 patients, though, are idiosyncratic human beings, not commodities. An OSCE score can have a high value
46 in a regulated market and yet be useless to new doctors and the real patients they treat.

54 The global dominance of neoliberalism explains why it may not be too far-fetched to suggest that
55 the institution of medical education is, as the previous paragraph suggests, misdirecting its effort.

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3 Neoliberalism is guided by the ideology that the ‘market’, and hence market-based solutions, are the most
4 efficient and effective way to address public sector problems. (Kearney *et al.*, 2019) ‘New Public
5 Management’ ([NPM]; Hood 1991, Griffith and Smith 2014) puts into practice neoliberal principles
6 (Kearney *et al.*, 2019), which include: hands-on professional management; applying private-sector
7 principles – including explicit standards and measures of performance - to professional practice; a stress
8 on results rather than procedures; and promoting competition to cut costs.(Hood, 1991) We hope this
9 explanation of contemporary ideology will help clinicians and educators understand the ‘mission creep’,
10 whereby politicians have turned ‘professionalism’ into staffing the production lines of state-controlled
11 and private for-profit institutions.
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14 We used the emotive word ‘destabilising’ in our title to remind readers of the tendency for stable
15 institutions to fossilise, and for their stability to become an unassailable ‘normal’. We have shown how
16 communal destabilisation for patient benefit can restore professional vitality rather than the anarchy that
17 conservative thinkers might fear. We suggest that a conjoint practice of caring, learning, and research is
18 achievable. Our humane institution should reconnect with its core values, shun NPM, and allow patients
19 and learners to arouse our involvement, effort, and excitement.
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